STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155297	A. BUILDING 00 B. WING	07/29/2011

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CONTINUING CARE CENTER OF LAPORTE HOSPITAL	1007 LINCOLNWAY LA PORTE, IN46350

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F0000	This visit was for a Recertification and State Licensure Survey. Survey dates: July 25, 26, 27, 28, and 29, 2011 Facility number: 000194 Provider number: 155297 Aim number: 100267790 Survey team: Kathleen (Kitty) Vargas, RN, TC Lara Richards, RN Janet Adams, RN Census bed type: SNF: 17 SNF/NF: 26 Total: 43 Census payor type: Medicare: 17 Medicaid: 13 Other: 13 Total: 43 Stage II Sample: 27 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed 8/4/11	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Cathy Emswiller RN			

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F0156 SS=C	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;			

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	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.			

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	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on interview and record review, the facility failed to provide ongoing information to the residents related to their rights, throughout the residents' stay in the facility. This deficient practice had the potential to affect 43 of 43 residents residing in the facility. (Resident #64 and Resident #38) Findings include: 1. Interview with Resident #64 on 7/28/11 at 11:05 a.m., indicated she did not recall any staff member discussing the resident rights with the residents during Resident Council Meetings or at any other meeting. The record for Resident #64 was reviewed on 7/29/11 at 9:05 a.m. The Quarterly MDS (Minimum Data Set) Assessment dated 6/3/11, indicated the resident's BIMS (Brief Interview for Mental Status) score was 15. A score of 13-15 indicated the resident	F0156	1. Resident #38 and #64 will have one on one with the Activity department staff to explain and review their resident' rights and continue to remind them of their resident rights2. any new resident has the potiental to be affected. Activities will visit each resident upon admission that is interviewable to make sure they received their resident rights upon admission and if they have any questions. Also at care plan meeting it will be addressed with resident and or family if resident rights are understood and if there is any questions. 3,4. The following systemic changes will be. During resident council a random resident right will be picked and discussed allowing time for scenarios and question and answers. Games and fun activities about resident rights will be included in monthly activies calendar. A monthly resident right will be posted in each resident room to be viewed by resident, family and staff 5. The Activities will implament the plan	08/28/2011

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	was cognitively intact. 2. Resident #38 was identified by the Administrator on 7/28/11 at 11:30 a.m., as alert and oriented and as frequently attending Resident Council Meetings. Interview on 7/28/11 at 1:30 p.m., with Resident #38, indicated the facility staff had not reviewed and talked to the residents about the resident's rights. The record for Resident #38 was reviewed on 7/29/11 at 9:10 a.m. The Quarterly MDS Assessment dated 5/3/11, indicated the resident had a BIMS score of 15 Interview with the Activity Director on 7/28/11 at 11:15 a.m., indicated she had not provided discussions related to the resident rights at the Resident Council Meetings. Interview with the Administrator on 7/28/11 at 2:15 p.m., indicated there had not been ongoing discussions with the residents related to resident rights. Review of the Resident Council Meeting minutes for the past year, indicated there was no documentation		of correction and the Administrator will monitor for continous compliance by reviewing minutes of the resident coucil meeting to assure resident rights are reviewed and random interview with residents regarding resident rights knowledge. Reporting results quartly to the Quality Assurance Committee.	

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	of a discussion of the resident rights during the meetings. 3.1-4(a)			
F0157 SS=D	A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, record review and interview, the facility failed to	F0157	1. Res. #18 had Norvasc Dc'd on 7/5/11 per MD D/T low blood	08/28/2011

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	ensure the residents' physician was notified in a timely manner of medications being held and the development of a new skin condition for 2 residents in the Stage 2 Sample of 27. (Residents #18 and #55) Findings include: 1. The record for Resident #18 was reviewed on 7/27/11 at 2:16 p.m. The resident's diagnoses included, but were not limited to, hypertension (high blood pressure) and sinus tachycardia (fast heart rate). A fax to the Physician's office dated 6/26/11, indicated the resident's Norvasc (a blood pressure medication) 10 milligrams (mg), Lasix (a water pill) 40 mg, HCTZ (hydrochloride thiazide-a water pill) and topical Nitro patch (a heart patch) were held on Saturday and Sunday related to the resident's low blood pressures. A return fax was received from the physician on 6/27/11, indicating to stop the HCTZ, reduce the Lasix to 20 mg daily and reduce Norvasc to 5 mg daily. A fax to the Physician's office dated 6/30/11, indicated the resident's Norvasc, Lasix, and Nitro patch were held on 6/29 and 6/30 due to low		pressures. Physician for resident #18 was contacted for guidelines as to when he would desire residents Lasix or Nitropatch be held if needed. MD gave order clarification on 8/11/11 stating that Lasix and Nitropatch to be held for systolic B/P under 100. Res #18's blood pressure has been in acceptable range since discontinuance of Norvasc. MD is to be notified if Lasix or Nitropatch medication is held. Res. #55 Abrasion of right forearm noted durning survey is completely healed. Family and physician were notified of residents previous abrasion present durning survey on 7/26/11. Notification documented in clinical note on res. record. 2,3.During a mandatory in-service on 8/19/11 procedure of notifying physicians and responsible parties for accident related injuries, condition changes, and alteration of treatment ordered was reviewed with all licensed nurses. Review of procedure in notifying physician who does not respond with in 24hrs. will be handled as follows: If attending physician is contacted regarding resident issue and does not respond within 24hours then the resident's nurse will follow up with the physician on call. If the on-call physician does not respond with in 24 hours the nurse will then contact the Continuing Care Center's Medical Director for intervention	

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	blood pressure. A return fax was received on 7/5/11, 5 days later, which indicated to stop the Norvasc 5 mg daily. A Physician's order dated 2/5/11, indicated to hold the Norvasc if the systolic blood pressure (top number) was less than 110 and the diastolic blood pressure (bottom number) was less than 50. There were no orders for parameters to hold the resident's Lasix and Nitro patch. Interview with the Director of Nursing on 7/29/11 at 12:30 p.m., indicated the resident's Lasix and Nitro patch had been held as a nursing measure. She further indicated the resident's physician didn't respond to the fax until 7/5/11 due to it had been a holiday weekend and the on call physician had not been contacted. 2. On 7/26/11 at 11:28 a.m., Resident #55 was observed with a bandaid to her right forearm. Surrounding the bandaid, were areas of pink and purple discoloration. On 7/27 at 8:38 a.m., 11:05 a.m., and 3:20 p.m., 7/28 at 9:00 a.m. and 2:15 p.m., and 7/29/11 at 8:50 a.m., the bandaid continued to be observed to the resident's right forearm. The		for resident and with the residents attending physician. All notifications will be documented on the residents medical record in clinical notes. In addition, process of notification of residents responsible party regarding any accident related inury was reviewed with licensed nurses at in-service conducted 8/19/11. Reviewed with licensed nurses the process of assessing and documenting any change noted in skin condition. Any abrasion, skin tear, excoriation or bruise will be assessed and documented in the residents reord as a clinical note. On going assessment and documentation will be done weekly by wond care nurse in res. clinical record and on weekly skin report to DNS. 4. All linceses nurses will be instructed to document any held medication on the daily 24 hours report. The DNS will randomly select individuals from the 24hr report who's medication has been held and will verify physican notification in the medical record on an on going monthly basis, and will report results to the Quality Assurance committee quarterly. This will be monitored by the DNS through observation rounds with the wound care nurse monthly and through the weekly skin reports. Findings will be reported to the Quality Assurance Committee. 5. Completion date 8/28/11.	

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	resident was observed with fading areas of reddish/purplish discoloration around the bandaid. The record for Resident #55 was reviewed on 7/27/11 at 2:54 p.m. The resident's diagnoses included, but was not limited to, anemia (low blood count). Review of the Nursing Progress notes for the month of July 2011, indicated there was no documentation related to an area on the resident's right forearm. There was also no documentation related to the physician being notified of the area. Interview with CNA #2 on 7/29/11 at 8:55 a.m., indicted she was not aware of what happened to the resident's arm. Interview with RN #2 on 7/29/11 at 9:10 a.m., indicated all that was being charted on was the resident's heel. She was not aware of what happened to the resident's arm. She indicated she did not usually work on the unit and she was not told of anything in report. She then proceeded to remove the bandaid and indicated the area could have possibly been from an old skin tear. She indicated the area was scabbed over.			

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	Interview with RN Case Manager #1 on 7/29/11 at 10:09 a.m., indicated she could not find anything in the resident's record related to what happened. She further indicated she could not find a treatment order nor where the physician was notified. 3.1-5(a)(2)			
F0278 SS=D	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. Based on observation, record review	F0278	1. Res #84 was interviewed by both the case manager and	08/28/2011

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	and interview, the facility failed to ensure the MDS (Minimum Data Set) Assessment accurately reflected the resident's oral/dental status, for 1 of 3 residents reviewed for dental status and services of the 7 who met the criteria for dental status and services. (Resident #84) Findings include: Resident #84 was observed in her room on 7/27/11 at 1:51 p.m. The resident was observed to have only 1 tooth in her mouth. It was on the bottom. Interview with the resident at that time indicated she only had the one tooth. The record for Resident #84 was reviewed on 7/27/11 at 2:00 p.m. The form titled "Dental and Oral Assessment" and dated 2/13/11, was reviewed. The form was completed by the dentist and indicated there was one tooth on the LL (lower left), tooth #21, in the resident's mouth. The Admission MDS (Minimum Data Set) Assessment dated 6/23/11, was reviewed. The MDS indicated there were no oral/dental issues. The MDS did not indicate that the resident had no natural teeth on top.		dietician regarding her single tooth and the dentists recommendation for extraction. Resident stated to both individuals she is having no pain or difficulties with tooth and does not wish to have this extracted. This is documented in the clinical notes by both case manager and dietician in resident record. Resident #84 inaccurate dental status on MDS of 6/23/11 noted during survey has been corrected to accurately reflect residents current dental/oral status.2,3. At inservice that will be conducted on 8/19/11 lincensed staff will be informed of procedure that all new admissions will have an admission oral assessment completed by the admitting nurse and results documented in the adult history assessment in the admission nursing nutrition section. This entry in turn will alert the dietician of any needed consult for follow up of any issue or concern identifed. The on going oral assessment will be addressed by contracted dentist who sees all new admissions during routine visits. Existing Continuing Care residents will be assessed annually and PRN by contracted dentist. The ongoing assessments completed by licensed nurses on admission and by denist post admission will be reviewed by each rsident's case manager and dietician prior to the completion of the MDS to ensure accuracy of MDS entries.	

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	Interview with Case Manager #2 on 7/27/11 at 3:05 p.m. indicated the MDS was inaccurately coded. Interview with the DON (Director of Nursing) on 7/28/11 at 2:30 p.m., indicated the MDS should have been coded correctly to indicate the loss of teeth. 3.1-31(d)		4. With each MDS the resident Case Manger will review the nursing oral assessment, Dental assessment, and dietician care plan to ensure all these entries coorelate and are accurate. Any discrepancies will be reported to the DNS for appropriate intervention by social service. Social services will complete these interventions and monitor all referred dental assessments for follow up on an ongoing basis each week as appropriate following dentist's visits.5. Completion date of 8/28/11	

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F0280 SS=D	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.			
	Based on record review and interview, the facility failed to revise the resident's care plan to ensure it reflected the resident's current status related to fluid restrictions for 1 of 1 residents reviewed for dialysis services of the 3 who received dialysis in the facility. (Resident #84) Findings include: Interview on 7/27/11 at 8:00 a.m., with the DON (Director of Nursing), indicated Resident #84 goes to dialysis three days a week on Monday, Wednesday, and Friday at 6:30 a.m. The record for Resident #84 was	F0280	1. resident #84's careplan entries by nursing and dietary have been corrected to currently reflect the status of her fluid restriction noted during survey on 7/27/112,3. All resident's with fluid restrictions could potentially be affected by this deficient practice. An in-service will be conducted on 8/19/11 and all licensed nurses will be notified that the new process will be to enter fluid restriciton order into the consult dietician screen of the resident's record which in turn will alert the dietician of restriction. The dietician will then notify the kitchen regarding the restriction and make the appropriate entry in the careplan. 4. This notification and accuracy of the careplan entry will be monitored by review of the careplan with the care plan	08/28/2011

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	reviewed on 7/27/11 at 2:00 p.m. The resident had diagnoses that included, but were not limited to, end stage renal disease, hypertension and congestive heart failure. The resident's current orders were reviewed. An order dated 6/14/11, indicated the resident's current diet was dental soft with a 2 gram potassium and 2 gram sodium restriction. On 6/17/11 there was on order to add 1500 cc (cubic centimeter) fluid restriction to the diet order. Review of the resident's care plans indicated a care plan dated 3/3/11, for hemodialysis related to renal failure 3 times per week for end stage renal disease. The intervention for "Fluid restriction 1500 ml (milliliters) daily," was crossed off with a notation that indicated the fluid restriction was discontinued on 7/15/11. There was a care plan dated 3/2/11, for impaired nutrition. The care plan was updated on 6/10/11. The 1.5 liter fluid restriction had a line drawn through it which indicated the fluid restriction had been discontinued. Interview with Case Manager #1 on 7/27/11 at 2:50 p.m., indicated the		team at each care conference during the residents stay. Any inaccuracies will be corrected by the careplan team at each conference. 5. Completion date 8/28/11.	

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	nutrition care plan and the hemodialysis care plan were not reflective of the resident's current status. She indicated the resident was currently on a fluid restriction and the care plans indicated the fluid restriction had been discontinued. 3.1-35(d)(2)(B)			
F0309 SS=D	Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure the necessary care and services were provided related to the development of a new skin condition for 1 of 3 residents reviewed of the 12 who met the criteria for non pressure related skin conditions. (Resident #55) Findings include: On 7/26/11 at 11:28 a.m., Resident #55 was observed with a bandaid to	F0309	1. Res. #55 Abrasion of right forearm noted durning survey is completely healed. Family and physician were notified of residents previous abrasion present durning survey on 7/29/11.2,3. All residents have the potential to be affected by this deficient practice. The process of notification of residents responsible party regarding any accident related inury will be reviewed with licensed nurses at in-service conducted 8/19/11. Will review with licensed nurses the process of assessing and documenting any change noted in	08/28/2011

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	her right forearm. Surrounding the bandaid, were areas of pink and purple discoloration. On 7/27 at 8:38 a.m., 11:05 a.m., and 3:20 p.m., 7/28 at 9:00 a.m. and 2:15 p.m., and 7/29/11 at 8:50 a.m., the bandaid continued to be observed to the resident's right forearm. The resident was observed with fading areas of reddish/purplish discoloration around the bandaid. The record for Resident #55 was reviewed on 7/27/11 at 2:54 p.m. The resident's diagnoses included, but was not limited to, anemia (low blood count). Review of the Nursing Progress notes for the month of July 2011, indicated there was no documentation related to an area on the resident's right forearm. Review of the non-decubitis ulcer flow sheets for the months of June and July 2011 on 7/29/11 at 10:30 a.m., indicated there was no documentation related to the resident's arm. Interview with CNA #2 on 7/29/11 at 8:55 a.m., indicted that she was not aware of what happened to resident's arm.		skin condition. Any abrasion, skin tear, excoriation or bruise will be assessed and documented in the residents record as a clinical note. On going assessment and documentation will be done weekly by wound care nurse in res. clinical record and on weekly skin report to DNS. Any skin condiction will be reported on the 24 hour nurse report and will be discussed in the morning meetings with care team. Wound Care Nurses will review 24hour report weekly for any alerts of new skin condictions requiring follow up. 4. This will be monitored by the wound care nurse weekly and the DNS through observation with rounds with the wound care nurse monthly on an on going basis. 5. Completion date 8/28/11.	

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	Interview with RN #2 on 7/29/11 at 9:10 a.m., indicated there was no documentation in the nursing progress notes related to the resident's right arm, the only skin condition that was being charted on was the resident's heel. She was not aware of what happened to the resident's arm. She indicated she did not usually work on the unit and she was not told of anything in report. She then proceeded to remove the bandaid and indicated the area could have possibly been from an old skin tear. She indicated the area was scabbed over. Interview with RN Case Manager #1 on 7/29/11 at 10:09 a.m., indicated that she could not find anything in the resident's record related to what happened. She further indicated she could not find a treatment order as well. 3.1-37(a)			

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F0315 SS=D	Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on observation, record review and interview, the facility failed to ensure 1 of 3 residents reviewed of the 3 who met the criteria for unjustified use of a foley catheter, had a diagnosis to support the use of the catheter. (Resident #55) Findings include: On 7/25/11 at 11:10 a.m., Resident #55 was observed to have an indwelling foley catheter in place. Interview with RN #3 on 7/25/11 at 11:34 a.m., indicated the resident had a foley catheter due to the diagnosis of urinary retention. The record for Resident #55 was reviewed on 7/27/11 at 2:54 p.m. The resident's diagnoses included, but was not limited to, urinary retention. A Physician's Orders/Patient Transfer Order form dated 11/18/10, indicated	F0315	1. Resident #55 Dr. Ranson urologist was consulted. Dr. Ranson stated that if the family agreed then the catheter for res. #55 could be removed. Family was notified of Dr. Ranson's consult and recommendation and family refused to have the catheter removed.2. Any resident that has a indwelling Catheter with the diagnosis of bladder retention could potential be affected. All residents that have this diagnosis are being evaluated and supporting documentation through consults or bladder scans are being provided to support the diagnosis of bladder retention. 3. Any new patient admitted with diagnosis of bladder retention without the appropriate supporting documentation will have their attending physician notified of the need for consult or testing to support diagnosis. 4. RN Case Managers will review any resident's record with diagnosis of urinary retention for supporting documentation during initial MDS completion. If supporting	08/28/2011

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	the resident was admitted to the unit with a foley catheter for urinary retention. The resident's Quarterly Minimum Data Set (MDS) Assessment dated 5/24/11, indicated the resident had an indwelling foley catheter, no trial toileting program was established and urinary incontinence was not rated due to the resident having a catheter. The plan of care dated 2/28/11 and reviewed on 7/25/11, indicated the resident had the potential for infection related to an indwelling foley catheter (16 french/5 cubic centimeter). For the diagnosis of urinary retention. A Physician's Order dated 4/13/11, indicated the foley catheter may be changed monthly and as needed. May irrigate foley with 3 milliliters (ml's) of sterile saline as needed. Perform catheter care with soap and water twice a day. The resident information sheet was reviewed on 7/29/11 at 9:00 a.m., and indicated the reason for the foley catheter was urinary retention. There was no supporting documentation in the resident's record for the diagnosis of urinary retention.		documentation is not present the Case Mangers will inform the resident's nurse of the need to contact Physician for supporting documentation and or testing. DNS will be notified of any lack of supporting documentation for diagnosis. DNS will montior for follow up in obtaining supporting documentation during daily team meeting with charge nurses on an on going basis. This process will be dicussed with all nursing personell on 8/19/11 through an inservice. 5. Completion date 8/28/11.	

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	A physician's order dated 7/28/11 at 3:30 p.m., indicated the resident was to be added to the Urologist's consult list for the diagnosis of urinary retention. Interview with the Director of Nursing on 7/28/11 at 12:30 p.m., indicated she had no additional documentation related to the supporting documentation for the foley catheter. 3.1-41(a)(1)			

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F0329 SS=D	Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure the resident's drug regimen was free from unnecessary drugs related to the lack of indication for the use of as needed anti-anxiety medications as well as the lack of interventions attempted prior to giving the medication and the lack of monitoring bowel movements for a resident who was receiving as needed narcotic pain medications for 2 of 10 residents whose drug regimens were reviewed for unnecessary drugs. (Residents #4 and #55)	F0329	1. Res #4 careplan has been updated to reflect risk of constipation symptomology related to narco. In review of res#4 BM record since survey reviewed and resident has had 6 BM's between 8/1 and 8/12/11. Res. #55 careplan was updated to include appropriate non-medication interventions to be attempted prior to the use of any PRN anti anxiety medication. Licensed nurses will document in a clinical note on the resident's record any signs of anxiety resident is exhibiting. 2,3. All residents are at risk of this deficiency. All licensed nurses will be trained at inservice on 8/19/11 regarding the process of	08/28/2011

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	Findings include: 1. The record for Resident #4 was reviewed on 7/27/11 at 8:53 a.m. An entry in the Nursing Progress Notes dated 7/24/11 at 7:41 p.m., indicated an order was received for Magnesium Citrate (a laxative) related to the resident not having a bowel movement in 6 days. The 6th floor BM (bowel movement) Care Record was reviewed on 7/29/11 at 12:10 p.m. No bowel movements were documented 7/19-7/24/11. A Physician's order dated 2/5/11, indicated the resident could receive a Dulcolax (a laxative) 10 milligram (mg) suppository as needed (prn) every day for constipation. Review of the July 2011 Medication Administration Record (MAR) on 7/29/11 at 9:30 a.m., indicated the resident had not received the prn Dulcolax suppository 7/19-7/24/11. A Physician's order dated 5/23/11, indicated the resident was to receive Norco (a narcotic pain pill) 7.5/325 mg 2 tablets by mouth every 6 hours prn pain.		documenting bowel status in the GI topical charting area of the residents record every three days. This process has been placed on the nurses task list. This will alert the license nurses to any resident who has not had a BM with in 3 days for intervention and follow up. CCC's Medical Director has been contacted and has been asked to establish a consistent, standardized bowel protocol. This protocal will be reviewed with all staff at the in-service on 8/19/11. In addition, all licensed nurses will be instructed on documenting non-medication interventions attempted prior to the administration of PRN anti-anxiety medication. Documentation is to occur in the PRN intervention screen where the nurse will fill out on the intervention checklist any interventions done and their level of effectiveness prior to the administration of PRN medication.4. These measures will be monitored by the CCC consultant pharmacist on an on going basis during monthly audits. These results will be reported to DNS monthly and to the quarterly Quality Assurance committe through her consultant reports.5. Completion date 8/28/2011	

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	Review of the 2010 Nursing Spectrum Drug Handbook on 7/29/11 at 12:00 p.m., indicated constipation could be a side effect of Norco. Review of the July 2011 MAR, indicated the resident received the prn Norco 7/19-7/24/11. Interview with LPN #1 on 7/28/11 at 2:35 p.m., indicated based on the resident's care plan, if a resident does not have a bowel movement within 4-5 days, prune juice was usually offered. She also indicated if it was not care planned, prune juice was usually offered within 3-4 days. It was usually based on the resident's normal bowel pattern. Interview with CNA #1 on 7/29/11 at 9:20 a.m., indicated the resident's BM's were documented on a record on the clip board. She further indicated if there has been no BM within 3 days, then prune juice was offered and if that doesn't work, the nurses' would give the resident something if they have anything ordered. Interview with RN Case Manager #2 on 7/29/11 at 12:15 p.m., indicated the resident had no BM's documented 7/19-7/24/11 and she had not			

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	received her prn Dulcolax suppository. 2. The record for Resident #55 was reviewed on 7/27/11 at 2:54 p.m. The resident's diagnoses included, but were not limited to, anxiety and dementia. A Physician's order dated 2/5/11, indicated the resident was to receive Lorazepam (an anti-anxiety medication) 0.25 mg by mouth twice a day prn for anxiety. A Physician's order dated 4/12/11, indicated the resident was to receive Valium 5 mg 1/2 tab by mouth every 8 hours as needed for anxiety. Review of the July 2011 Medication Administration Record (MAR), indicated the resident received the prn Valium on 7/20 at 1:00 p.m., 7/23 at 1:57 p.m., and on 7/28/11 at 8:44 p.m. The July 2011 MAR, indicated the resident received the prn Lorazepam on 7/20 at 9:00 a.m., 7/21 at 9:00 a.m., 7/22 at 10:45 a.m., 7/23 at 8:44 p.m., 7/24 at 9:19 a.m., and 7/26/11 at 8:35 a.m. There was no documentation in the			

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	Nursing Progress notes for the above dates related to episodes of anxiety. Further, behavior/intervention sheets had not been completed prior to giving the medications for the above dates. Interview with RN Case Manager #1 on 7/29/11 at 12:30 p.m., indicated there was no documentation to support the use of the medication and no behavior intervention sheets had been completed for the above dates. 3.1-48(a)(3) 3.1-48(a)(4)			
F0412 SS=D	The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.			

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	Based on observation, record review and interview, the facility failed to ensure each resident received the dental services as recommended by the Dentist, for 1 of 3 residents reviewed for dental status and services of 7 who met the criteria for dental status and services. (Resident #84) Findings include: Resident #84 was observed in her room on 7/27/11 at 1:51 p.m. The resident was observed to have only 1 tooth in her mouth. It was on the bottom. Interview with the resident at that time, indicated she only had the one tooth. The record for Resident #84 was reviewed on 7/27/11 at 2:00 p.m. The Admission MDS (Minimum Data Set) Assessment, dated 6/23/11, indicated the resident could understand, be understood and had a BIMS (Brief Interview for Mental Status) score of 15. A score of 13-15 indicated the resident was cognitively intact. The form titled "Dental and Oral Assessment" and dated 2/13/11, was reviewed. The form was completed by the Dentist and indicated there was	F0412	1. Resident number #84 was interviewed by the case manager as well as by the dietician letting her know that the dentist recommended for her tooth to be extracted in progress note from his last visit. Resident #84 stated she she is having no pain, she is eating and drinking fine and did not want to have the tooth extracted. This response was documented in the resident record and care planned. 2,3. All current residents that have seen the dentist have the potental of being affected by this deficiency. All current resident records will be reviewed for any dental recommendations making sure all recommendations are followed up on. Review of records are to be completed by DNS by 8/28/11. 4. The post admission dental assessments by the dentist will be reviewed by each resident's case manager and dietitician prior to the completion of the MDS to ensure accuracy of MDS entries as well as making sure all denist's recommendation are addressed. The unit coordinator will review dentist assessments prior to putting them in the resident's chart. If recommendations are noted unit coordinator will alert Social Service designees of recommendation. Social Service designees with follow up on recommendations on an on going basis each week as is appropriate following dentist's visit to assure	08/22/2011

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	one tooth on the LL (lower left), tooth #21, in the resident's mouth. The Dentist indicated, "LL tooth will need extraction." Review of the Case Manager progress notes dated 2/13/11 through 7/27/11, indicated there was no documentation the Case Manager had provided dental services for the tooth extraction. There was no documentation of an investigation of the resident's wishes related to the recommendation to have the tooth extracted. On 7/28/11 at 8:55 a.m., Case Manager #1 was interviewed. She indicated she was unaware of the Dentist's recommendation, documented in the record on 2/13/11. She was not aware the Dentist had recommended the extraction of the resident's tooth. She indicated she was the person responsible for providing follow up services for dental care when warranted or recommended by a physician or a dentist. She indicated she had not followed up on the dental recommendation. She indicated she should have been aware of the recommendation and should have spoken to the resident about her wishes related to the extraction.		this deficient practice does not recur. 5. New process will be in place and implemented by 8/28/11.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	3.1-24(a)(1)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155297	A. BUILDING 00 B. WING	07/29/2011

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F0441 SS=E	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review and interview, the facility failed to ensure the glucometer was disinfected before and after use for 1 of 1 glucometer testing observed.	F0441	1. On 7/25/2011 the current policy for disinfecting the glucometer was reviewed with all licensed nursing staff during the survey to ensure cleaning of the glucometer before and after	08/19/2011

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	This had the potential to affect the 4 residents who received glucometers on the 6th floor. (Resident #4) Findings include: On 7/27/11 at 11:18 am, RN #1 was observed doing a glucometer check (a test to check the resident's blood sugar) for Resident #4. When the RN removed the glucometer from the case, she did not disinfect the machine. After obtaining the resident's blood sugar, the RN placed the glucometer back in the case. Again, she did not disinfect the machine after it was used and prior to putting it away. Interview with the RN at the time, indicated the glucometer was cleaned on midnights and as needed. The facility policy titled "Cleaning of Accu-chek inform system monitor" was reviewed on 7/27/11 at 12:55 p.m. The policy was provided by RN #1 and identified as current. The policy indicated the Accu-Chek Inform System Monitor must have the exterior surface cleaned/disinfected daily prior to and after each patient use. Interview with RN #1 on 7/27/11 at		each per policy. 2. Any resident that we have glucometer check ordered for could potentially be affected by this deficiency. Our current policy as stated in #1. will be followed. 3. Policy titled "Cleaning of Accu-chek Inform System Monitor" will be reviewed with all nursing personell on the Continuing Care Center again at the inservice on 8/19/11. The Accu Check glucometer disinfecting policy states external surface of glucometer will be cleansed with bleach wipes, and glucometer screen will be cleansed with alcohol wipes before and after each use. Pharmacy technicians will monitor this practice during the medication pass audits quarterly to ensure policy is being followed. 4.Pharmacy technicians will monitor the following of this policy during medication pass audits quarterly and the consultant pharmacist will report any deficiencies to the DNS in her ongoing written reports and any noted deficiencies will be reported to the quarterly Quality Assurance Committee. 5. Completion date 8/28/11.	

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	12:50 p.m., indicated the glucometer was to be cleaned prior to and after each use and that she had been incorrect in not doing so. Interview with the Director of Nursing on 7/29/11 at 1:30 p.m., indicated there were 4 residents who resided on the 6th floor and received routine glucometer checks. 3.1-18(b)(1)			